Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Hamilton Service Area Office
119 King Street West 11th Floor
HAMILTON ON L8P 4Y7
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Public Copy/Copie du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Feb 14, 2019	2018_661683_0020	003825-18	Follow up

Licensee/Titulaire de permis

The Regional Municipality of Niagara
1815 Sir Isaac Brock Way THOROLD ON L2V 4T7

Long-Term Care Home/Foyer de soins de longue durée

Linhaven
403 Ontario Street St. Catharines ON L2N 1L5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

LISA BOS (683), ROSEANNE WESTERN (508)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Follow up inspection.

This inspection was conducted on the following date(s): December 17, 18, 19, 20 and 21, 2018, and January 2, 3, 4, 7, 9, 10, 11, 14, 15, 16, 17, 18, 22 and 23, 2019.

This inspection was completed concurrently with critical incident inspection #2018_661683_0021 and complaint inspection #2018_661683_0022.

The following intakes were completed during this follow up inspection:
log #029395-17 / M551-000037-17 - related to the prevention of abuse and neglect
log #026648-18 / M551-000035-18 - related to the prevention of abuse and neglect

PLEASE NOTE: A Written Notification and Compliance Order related to LTCHA, 2007, c.8, s. 19(1) and s. 20(1), identified in a concurrent inspection #2018_661683_0021 (log #026648-18, CIS #M551-000035-18) was issued in this report. A Written Notification related to LTCHA, 2007, c.8, s. 19(1), identified in a concurrent inspection #2018_661683_0021 (log #029395-17, CIS #M551-000037-17) was issued in this report.

During the course of the inspection, the inspector(s) spoke with the Administrator, the Director of Resident Care (DRC), the Associate Directors of Resident Care (ADRC), the Manager of Long Term Care Behavioural Support and Convalescent Care, the Dietitian, the Resident and Family Support Worker, registered staff, Personal Support Workers (PSW), residents and families.

During the course of the inspection, the inspector(s) reviewed resident clinical records, reviewed policies and procedures, reviewed investigation notes, reviewed training records, reviewed the complaints log, reviewed meeting minutes, reviewed program evaluation records and observed residents during the provision of care.

The following Inspection Protocols were used during this inspection:
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.

2 WN(s)
0 VPC(s)
1 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

A) A review of Critical Incident (CI) log #026648-18 / M551-000035-18, indicated that resident #014 had an identified diagnosis and had identified responsive behaviours.

On an identified date, resident #014 was observed by Registered Practical Nurse (RPN) staff demonstrating physical responsive behaviours towards resident #015. Staff immediately intervened and separated the residents. Resident #015 sustained identified injuries in the altercation.

It was confirmed during review of the resident's clinical records and during interview with staff #121 that the licensee failed to ensure that residents were protected from abuse by anyone.

B) A review of the clinical record for resident #014 indicated that the resident had an identified diagnosis and had identified responsive behaviours.

On an identified date, resident #014 was observed by RPN staff demonstrating physical responsive behaviours towards resident #015. Staff immediately intervened however, resident #015 sustained identified injuries in the altercation.

The resident's plan of care was reviewed and revised after this incident and specific interventions were implemented.

On an identified shift, on an identified date, a specific intervention was in place for resident #014 as indicated in their plan of care. During the identified shift, the identified intervention was shared between an identified number of residents.

At an identified time, registered staff #119 heard a sound and witnessed an altercation between resident #015 and resident #018. Documentation also indicated that an identified intervention did not alert staff and PSW #120 indicated in their statement that at the time of the incident, the identified intervention was removed.

Resident #018 sustained identified injuries as a result of the altercation and they received treatment for the identified injuries.

During interview with staff #121, they indicated that resident #014 should have had the identified intervention in place due to the previous incident that occurred on an identified date, and that this intervention was implemented to minimize a re-occurrence.

It was confirmed during interviews, record reviews and investigative notes that resident #018 was not protected from abuse by anyone.

C) The following is further evidence to support the order issued on February 13, 2018, during Resident Quality Inspection #2017_560632_0023 to be complied March 23, 2018.

A review of CI log #029395-17 / M551-000037-17, indicated that resident #008 had an identified diagnosis and exhibited responsive behaviours.

On an identified date, resident #008 was witnessed by PSW #122 demonstrating behaviours towards resident #009. Resident #009 had an identified diagnosis and an identified cognitive status.

Due to a history of responsive behaviours towards co-residents, the home had implemented an identified intervention to minimize the risk of further incidents occurring; however, the identified intervention was implemented only at identified times.

During interview with PSW #122 who witnessed the incident, the time of the incident was just prior to an identified time and when they witnessed the incident no staff were assigned to implement the identified intervention for resident #008. During interview with the Administrator on an identified date, they indicated that the identified intervention was not implemented until an identified date, after this incident occurred.

It was confirmed during review of the documentation and during interviews with staff that the licensee failed to ensure that residents were protected from abuse by anyone.

PLEASE NOTE: This example of non-compliance will be issued as a Written Notification (WN) as the incident occurred prior to the compliance order due date of March 23, 2018. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 20. Policy to promote zero tolerance

Specifically failed to comply with the following:

s. 20. (1) Without in any way restricting the generality of the duty provided for in section 19, every licensee shall ensure that there is in place a written policy to promote zero tolerance of abuse and neglect of residents, and shall ensure that the policy is complied with. 2007, c. 8, s. 20 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy that promoted zero tolerance of abuse and neglect of residents was complied with.

A review of the homes policy, "Abuse and Neglect - Zero tolerance (Index No: RR00-001)," with an identified revision date, revealed that under Procedure - Reporting and Investigation of Abuse and Neglect: 14 "The Administrator/DRC/Charge Nurse will notify the Ministry of Health and Long Term Care (MOHLTC) via phone immediately. The Administrator/DRC or delegate will complete the Critical Incident report on the Ministry website as indicated in the policy (ADO5-002) Reports, Complaints-Mandatory and Critical Incidents Report Requirements."

A review of the clinical record for resident #014 indicated that the resident had identified responsive behaviours.

On an identified date, an altercation was witnessed between resident #014 and resident #018. Resident #018 sustained identified injuries as a result of the incident.

Documentation in the resident's clinical record and interview with registered staff #117 on an identified date confirmed that on the date of the incident the Manager-on Call had been contacted by the Registered Nurse (RN) regarding the incident which occurred; however, the Ministry of Health and Long Term Care had not been notified via phone and a Critical Incident report had not been submitted even after an investigation had been conducted by the home.

It was confirmed during record reviews and interviews with staff #117 and staff #121 that the home's policy of abuse and neglect of residents was not complied with. [s. 20. (1)]

Issued on this 25th day of February, 2019

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Ordre(s) de l'inspecteur

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	LISA BOS (683), ROSEANNE WESTERN (508)
Inspection No. / No de l'inspection :	2018_661683_0020
Log No. / No de registre :	003825-18
Type of Inspection / Genre d'inspection:	Follow up
Report Date(s) / Date(s) du Rapport :	Feb 14, 2019
Licensee / Titulaire de permis :	The Regional Municipality of Niagara 1815 Sir Isaac Brock Way, THOROLD, ON, L2V-4T7
LTC Home / Foyer de SLD :	Linhaven 403 Ontario Street, St. Catharines, ON, L2N-1L5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Cindy Perrodou

To The Regional Municipality of Niagara, you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # /
Ordre no : 001

Order Type /
Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order /
Lien vers ordre existant: 2017_560632_0023, CO #001;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 of the LTCHA.

Specifically, the licensee shall ensure that:
1. Resident #009, #015, #018 and all other residents are protected from abuse by anyone.
2. Residents who are requiring a specific staff intervention are monitored at all times, or as identified in their plan of care.
3. On-going quality monitoring activities are implemented to ensure that residents are not abused by co-residents. Documentation of what quality monitoring activities were completed, when they were completed, and the results of the quality monitoring activities are to be maintained by the home.
4. An evaluation is made to determine the effectiveness of the licensee's policy to promote zero tolerance of abuse. The evaluation is to identify the number of incidents of actual or alleged abuse in 2018, any trends identified, what was done to prevent recurrence, and specific improvements made to the abuse program to ensure the safety of all residents.

The licensee has failed to comply with the following compliance order (CO) #001 from inspection #2017_560632_0023 served on February 13, 2018, with a compliance date of March 23, 2018.

The licensee was ordered to:
1. Ensure that all residents are protected from abuse by anyone and free from neglect by the licensee.
2. Ensure that interventions are in place for residents #014, #024, #025 and #027 to manage the residents' responsive behaviours.
3. Ensure staff follow residents #014, #024, #025 and #027 plans of care, when managing the residents' responsive behaviours.

The licensee completed steps 2 and 3 in CO #001.
The licensee failed to complete step 1 regarding protecting all residents from abuse by anyone.

Grounds / Motifs :

1. The licensee failed to ensure that residents were protected from abuse by anyone.

A) A review of Critical Incident (CI) log #026648-18 / M551-000035-18, indicated that resident #014 had an identified diagnosis and had identified responsive behaviours.

On an identified date, resident #014 was observed by Registered Practical Nurse (RPN) staff demonstrating physical responsive behaviours towards resident #015. Staff immediately intervened and separated the residents. Resident #015 sustained identified injuries in the altercation.

It was confirmed during review of the resident's clinical records and during interview with staff #121 that the licensee failed to ensure that residents were protected from abuse by anyone.

B) A review of the clinical record for resident #014 indicated that the resident had an identified diagnosis and had identified responsive behaviours.

On an identified date, resident #014 was observed by RPN staff demonstrating physical responsive behaviours towards resident #015. Staff immediately intervened however, resident #015 sustained identified injuries in the altercation.

The resident's plan of care was reviewed and revised after this incident and specific interventions were implemented.

On an identified shift, on an identified date, a specific intervention was in place for resident #014 as indicated in their plan of care. During the identified shift, the identified intervention was shared between an identified number of residents.

At an identified time, registered staff #119 heard a sound and witnessed an altercation between resident #015 and resident #018. Documentation also indicated that an identified intervention did not alert staff and PSW #120 indicated in their statement that at the time of the incident, the identified intervention was removed.

Resident #018 sustained identified injuries as a result of the altercation and they received treatment for the identified injuries.

During interview with staff #121, they indicated that resident #014 should have

had the identified intervention in place due to the previous incident that occurred on an identified date, and that this intervention was implemented to minimize a re-occurrence.

It was confirmed during interviews, record reviews and investigative notes that resident #018 was not protected from abuse by anyone.

The severity of this issue was determined to be a level 3 as there was actual harm to the residents. The scope of the issue was a level 2 as it was related to three out of five residents. The home had a level 4 compliance history of on-going non-compliance with this section of the Act that included:
• CO served on February 13, 2018 (#2017_560632_0023) (508)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Apr 30, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 14th day of February, 2019

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Lisa Bos

Service Area Office /
Bureau régional de services : Hamilton Service Area Office